STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST INDIANAPOLIS, IN 46219

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R000000	R000000 This visit was for State Residential Licensure Survey. Survey dates: December 29, 30, & 31, 2014 Facility number: 005729 Provider number: 005729 AIM number: N/A Survey team: Beth Walsh, TC-RN (December 29 & 31, 2014) Tom Stauss, RN Angie Stallsworth, RN (December 31, 2014) Census bed type: Residential: 61 Total: 61 Census payor type: Medicaid: 58 Other: 3 Total: 61 Sample: 8 These state deficiencies are cited in accordance with 410 IAC 16.2-5.	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on January 8, 2014 by Cheryl Fielden, RN.			
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a resident's service plan was updated and reviewed for 1 of 7 residents whose service plans were reviewed. (Resident #121)	R000217	RE: R0217 Submission of this plan of correction does not constitute admission of guilt. All residents in the facility were at risk for the potential of harm by such deficiency. No residents	01/30/2015

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	Findings include: Resident #121's record was reviewed on 12/29/14 at 11:19 a.m. The resident's diagnosis included, but were not limited to, expressive aphasia. On 12/29/14 at 10:48 a.m., during an interview, Resident #121 was unable to articulate appropriate verbal responses to questions due to a diagnosis of expressive aphasia. When questioning was framed in yes or no format the resident was able to adequately communicate his thoughts and ideas. He used to have a communication device, after the device was recommended by a speech therapist, that aided him in communication with staff. He has not had the device for at least 3 months. He described using the device to aid his communication with staff and the device was helpful to him. A physician's order, dated 4/21/14, indicated Resident #121 was to receive speech therapy services. A physician's certification, dated 12/3/14, indicated Resident #121 had a "...need for communication device..." and had "...extremely limited communication..." related to a previous stroke and aphasia		were found to have been harmed. In regards to the facility's failure to ensure that a residents care plan was updated and reviewed a review of our service plans and the methods in which they are reviewed and updated has been completed and the service plan has been will be updated to better include more specific information regarding a residents ability to send and receive communication to include areas of deficits and aides or methods used to communicate. Also when a resident is unable to sign he or her name resident will be asked to make a mark of an "X" and it will be witnessed by a third party The updated form will be uploaded for your review. This form will be implemented by month end and will be used going forward with all new admits and readmits. All nursing staff who is responsible for admits and readmits will be trained on the use of the new forms. The Director of Health Services or her designee will be responsible for following up on all new admits and readmits to double check that all documentation is in order and that all new orders have been followed through with. This is to be completed within 24 hours of the admit or readmission.	

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	(communication impairment). A speech therapy evaluation, dated 4/25/14, indicated Resident #121 had significant speech limitations due to expressive aphasia. The assessment described how the resident was not able to accurately communicate his needs verbally, but was able to use gestures, point, and indicate some yes or no answers. A 5/8/14 speech therapy progress note indicated the therapist introduced a "Augmentative Communication device" (a communication tool) to Resident #121. The resident was instructed on how to use the device to express "wants/needs/activities". The assessment indicated the resident was "excited regarding AAC (electronic speech assistive tool) device" the DON (Director of Nursing) and ADON (Assistant Director of Nursing) were educated on the device. A 5/9/14 speech therapy progress note indicated Resident #121's mother and facility nursing and housekeeping staff was "educated on AAC device" and indicated how the "AAC device will (increase) communication." A 5/27/14 speech therapy progress note			

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	indicated Resident #121 utilized a communication device "...to report today's (sic) events..." The resident was able to identify what he ate for lunch independently with the use of the communication tool. Resident #121's service plan, dated 3/24/14, did not indicate Resident #121 had a communication impairment. A document for Resident #121, titled "Service Plan Record of Review" indicated Resident #121's service plan was reviewed on 3/24/14 and 9/24/14. The resident's signature was not listed in the "Resident Signature" area on the 3/24/14 and 9/24/14 service plans. On 12/29/14 at 12:44 p.m., during an interview, Dietary Aide #6 indicated Resident #121 did not use a formal communication aid. Staff would continue to question the resident and provide specific choices for which the resident could reply yes or no. On 12/30/14 at 10:31 a.m., during an interview, the DON indicated Resident #121's had occasionally used a "communication board" which contained pictures with short descriptions of emotions or ideas, and had temporary use of an electronic communication tool			

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	which helped the resident communicate his thoughts, ideas, and needs. The resident's service plan should have been updated to reflect his need to use communication aids and to describe his communication challenges. She was not sure what happened to the communication board or why staff was not aware of its use. The facility reviewed service plans with residents or family members and would have the family member or resident sign the service plan. The DON was unable to provide evidence that Resident #121's service plan was reviewed with the resident or a family member. On 12/30/14 at 12:19 p.m., during an interview, LPN #3 indicated she was not aware of any formal communication aid used for Resident #121. Staff would provide choices for the resident to choose from and the resident could communicate his needs and preferences by identifying from the choices. A facility policy on service plans, dated December of 2003 and titled "EVALUATION OF INDIVIDUAL RESIDENT NEEDS" indicated the facility "...shall identify and document the services provided to the resident by the facility, in the form of a service plan..." and "...The services offered shall			

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	be reviewed and revised as appropriate..." and "...The agreed upon service plan shall be signed and dated by the resident..."			
R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.			
	Based on observation, interview, and record review, the facility failed to provide documentation of physician notification for drug administration/physician's order of a medication a resident had a documented allergy to. The facility also failed to follow physician's orders to monitor blood pressure and heart rate prior to medication administration. This had the potential to affect 2 of 5 residents reviewed for physician's orders. (Resident #232 & #224) Findings include: 1. The clinical record for Resident #232 was reviewed on 12/29/14 at 12:07 p.m. The diagnoses for Resident #232 included, but were not limited to, traumatic brain injury, dyspena, chronic obstructive pulmonary disease, and fibromyalgia.	R000247	RE: R0247 Submission of the plan of the correction does not constitute an admission of guilt. All residents in the facility were at risk for the potential of harm by such deficiency. No residents were found to have been harmed. In regards to the facility's failure to provide documentation of physician notification for a drug administration/physician order of a medication a resident had documented allergy to and in regards to the facility failing to follow physician's orders to monitor blood pressure and heart rate prior to medication administration. Corrective actions taken for resident 232 were as stated in the survey, an order was obtained from the doctor to d/c the allergy due to the fact that the resident had been taking the medication for quit some time without any adverse effects or allergy symptoms Corrective actions for resident 224, for this resident an order was obtained	01/30/2015

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	During a medication administration observation with LPN #3, on 12/29/14 at 11:32 a.m., LPN #3 administered oxycodone/acetaminophen (Percocet-pain medication) 10/325 milligram to Resident #232. A Resident Information sheet located in the clinical record indicated Resident #232 was allergic to Percocet. The October, November, & December Physician's Orders indicated Resident #232 had an allergy to acetaminophen, hydrocodone, and oxycodone. The Physician's Orders also indicated an order for oxycodone/acetaminophen (Percocet) 10/325 milligrams to be taken 4 times a day. The November MAR (medication administration record) indicated Resident #232 received Percocet 11/1/14-11/30/14, as ordered. The December MAR indicated Resident #232 received Percocet 12/1/14-12/29/14, as ordered. During an interview with the Director of Nursing (DON), on 12/29/14 at 1:50 p.m., the DON indicated the facility addressed the documented allergies and		from the doctor to d/c this nursing home doctors order for daily blood pressure checks prior to administering medication due to the fact that this resident has been taking this medication for over 2 years and monthly blood pressures readings have shown that the resident bp has been controlled with the current medication In and effort to prevent this from happening again or to prevent this from happening to any current residents, several new items will be put in to place 1. Currently all residents records are undergoing a review of medication administration protocol for both prescription and non prescription drugs for each resident are accurate and up to date, a review for allergies, if it is found that any medication is being given that contains an allergen to a resident , that resident's doctor will be immediately notified and a request to either continue the medication and d/c the allergy or to d/c the medication and follow up orders will be requested. all charts will be marked with an allergy alert sticker, the pharmacy has been notified of our issue and a request has been made for the pharmacy to notify the facility if a prescription was sent directly to the pharmacy from the doctor and a medication is found to have an allergen and if the pharmacy receives clarification of an order	

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	the medication administration/order with a Physician "awhile ago" and the DON was unable to further provide an explanation of a timeframe. A Physician's Order, dated 12/31/14, indicated an order for discontinuation of Resident #232 allergy to Percocet and "Codone." The Physician's Order was provided by the DON on 12/31/14 at 12:05 p.m. On 12/31/14 at 12:10 p.m., the DON indicated she was unable to locate documentation of Physician notification of a documented allergy to oxycodone/acetaminophen. The DON further indicated it was hard to keep track of Resident #232's orders because Resident #232 changes Physicians often. 2. The clinical record for Resident #224 was reviewed on 12/29/14 at 1:37 p.m. The diagnoses for Resident #224 included, but were not limited to, congestive heart failure, acute renal failure, and diabetes mellitus. A Readmission Physician's Order, dated 12/23/14, indicated metroprolol succinate ER 25 mg (milligrams) tab was to be given every morning and to hold the medication for a blood pressure less than 110 or a heart rate less than 60.		from the doctor that they forward a copy of said clarification with the prescription delivery. 2 all residents will be addressed in the next resident council meeting with a request to deliver all new orders from any doctors visit to the nursing staff immediately upon return to the facility after their appointment 3 written communication will be mailed to all residents and their responsible parties again requesting that all orders from doctors visits be delivered to the nursing staff upon return to the facility A new tracking document has been created and will be implemented by month end for all new admits and readmits and new orders delivered to the facility going forward A copy of the nursing admit/readmit assessment record form has been uploaded for your review, This form will create a mode for follow up on all new orders as well as vitals per shift for first 24 hours by multiple staff , The Director of Health Services or her designee will be responsible for the auditing of the new assessment records for all new admits and readmits, or new orders received with in 24 hours to double check that all documentation is in order and that all new orders have been followed through with. This is to be completed within 24 hours of the admit or readmission or receipt of new orders. All nursing staff will be trained on the proper	

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	The December MAR indicated Resident #224 was administered metroprolol 12/24/14-12/29/14. No blood pressures or heart rates were noted on the MAR. During an interview with the DON, on 12/29/14 1:51 p.m., the DON indicated a blood pressure and heart rate were not required prior to administration of metroprolol. The DON further indicated there might be another sheet with vital signs, if someone "caught" the order. On 12/31/14 at 10:12 a.m., the DON indicated blood pressures or heart rates have not been obtained prior to administration of metroprolol since the Resident has been on the medication. The DON further indicated she requested an order to discontinue the order for a blood pressure and heart rate prior to the medication administration.		use of the form during a mandatory meeting on 2/3/2015 There will also be a monthly audit conducted by the director of health services or her designee on the monitoring of medication administration and allergies and service plans as well as monitoring of medication administration . this monthly audit will continue indefinitely. this audit will be monitored and review by the HFA	
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure kitchen utensils were kept from being stored inside bulk food containers of	R000273	RE:0273; Submission of this plan of correction does not constitute a admission of guilt. All residents have the potential of harm, no residents were found to have	01/30/2015

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	sugar and flour. Findings include: On 12/30/14 at 10:58 a.m., during an observation of the kitchen, two bulk food items (sugar and flour) had clear plastic scoop utensils lying inside the sugar and flour products. They were being stored in clear plastic containers. On 12/30/14 at 11:01 a.m., during an interview, the Dietary Manager indicated scoop utensils should never be left inside any bulk food items as utensils could potentially cause contamination of those food items. She indicated the correct procedure was for a scoop to be used in a bulk food item and then washed and dried prior to reusing the scoop with any other food item. She also indicated the facility does not have a policy regarding keeping utensils in bulk food items. On 12/31/14 at 9:57 a.m., the Administrator indicated kitchen utensils should never be left inside bulk food items. A facility policy, undated and titled "Food Storage" indicated "Facility will refer to the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24"		been harmed. To correct this matter, all scoops have been removed from the kitchen and replaced with long handled measuring utensils. An all staff in-service was conducted on 1/23/2015 by the HFA and All staff present including all dietary staff and dietary manager have now been re-trained on the proper method of storage of and measuring of bulk staples such as sugar and corn meal to also include the cleaning and storing of measuring utensils and all single use items. Staff who were not in attendance will also be in-serviced on the above by 1/31/2015. The Dietary Manager will be responsible for auditing of the deficient practice to ensure that it does not happen again This will be done one to two times a week for 6 months. After 6 months this will continue to be audited once a week indefinitely by the dietary manager. This will be monitored by the dietary manager on an ongoing basis.	

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R000382	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on interview and record review, the facility failed to create a comprehensive care plan with interventions for a resident with the diagnosis of a major mental illness. This had the potential to affect 1 of 7 residents reviewed for service plans. (Resident #129) Findings include: The clinical record for Resident #129 was reviewed on 12/31/14 at 11:00 a.m. The current diagnosis included, but were not limited to, bipolar effective disorder, psychosis, anxiety, altered mental status, and acute encephalopathy. A Service Plan, dated 1/19/14, indicated, "...K. Individual Needs Assessments (complete only if resident has a major mental health issue): Major Mental Health Diagnosis: Depression, Psychosis Mental Health Provider: [Name of Provider], Social Needs and Preferences: [area left blank]...., N. Behaviors/Interventions/Outcomes/Reco	R000382	RE: 0382; Submission of this plan of correction does not constitute an admission of guilt. All residents had the potential to have been harmed. No residents were found to have been harmed. Corrective Action for this resident will not be possible, this resident was hospitalized at the time of survey and due to the his recent decline in health, the resident was transferred from the hospital to a nursing home and will not be returning to our facility as his level of care is now beyond our scope of care for this facility For all other residents in house a complete review and update of service plans to include specific assessment as "Individual Needs Assessment /Comprehensive Service Plan " (to be completed if a resident has a major mental health diagnosis)This will be completed if needed along with a new service plan All current residents service plans will be reviewed and updated on a quarterly basis, and also at return from a hospital stay, rehabilitation, nursing home stay or any time there is a change in mental status, changes in	02/27/2015

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	mmendations: NONE..." An Evaluation of Needs/Service Plan indicated the Service Plan was reviewed on 6/20/14 and 10/21/14. A Medication Self Administration Assessment, dated 1/19/14, indicated Resident #129 was to self administer his medication. The Quarterly Re-Assessment, of the Medication Self Administration Assessment dated 4/16/14, indicated,"...Res [Resident] has hallucinations [symbol for and] psychosis-was not taking meds on his own. MD [Physician] order to have NSG [Nursing] staff give meds..." The Quarterly Re-Assessment, of the Medication Self Administration Assessment dated 7/10/14, indicated, "...Same med [medication] admin [administration] plan..." The Quarterly Re-Assessment, of the Medication Self Administration Assessment dated 10/2/14, indicated, "cont [continue] same med admin plan..." An interview with the Director of Nursing (DON) was conducted on 12/31/14 at 11:50 a.m. The DON indicated Resident #129 was self administrating medication until he was sent to the hospital for an "overdose." The DON further indicated after the hospitalization, the facility began to		interventions or changes in over all health that requires an update due to change in needs or alterations in services. It will also be reviewed and updated upon the of resident, family, per doctors orders or anytime deemed clinically necessary , but no less than quarterly This audit will be conducted by the director of health services or her trained designee the updated service plan which will now include the comprehensive care plan will be reviewed with the resident and/or their responsible representative and signed and witness by clinical staff To ensure that the highest possible level of quality assurance is being provided, these audits will continue in an regularly ongoing fashion indefinitely. In regards to the facility failing to have created a comprehensive care plan with interventions for a resident with the diagnosis of a major mental illness. Our residents Evaluation Service Plan has been updated to include a more specific individual needs assessment/comprehensive care plan to be completed if the resident has a diagnosis of a major mental illness. All current resident service plans will be reviewed and if needed the comprehensive care plan will be added . This review and update of all current residents service plans will be completed by 2/10/2015. This new form will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	administer the resident's medication because several medications were found in Resident #129's room after he was sent to the hospital. The DON indicated she was unsure of when the non-administered medication was found in the resident's room. On 12/31/14, at 1:12 p.m., the DON indicated she was unaware a service/care plan was needed to address behaviors and diagnoses for a resident who was a recipient of [Resident #129's insurance] and had a major mental illness. The DON indicated Resident #129 does have a history of "pocketing" medication in which the behavior should have been addressed on the service/care plan. The Administrator indicated on 12/31/14 at 1:56 p.m. the facility has had several concerns with Resident #129 not taking his medication as ordered and the facility needed to start administrating medications to the resident. The policy, "EVALUATION OF INDIVIDUAL RESIDENT NEEDS," no date, was provided from the Administrator on 12/31/14 at 11:00 a.m. and indicated the following: "...Assessments will address the resident's physical/mental status, independence with activities of daily living and weight.		used for all new admits going forward and at anytime a diagnosis of a major mental illness is given A training session is scheduled for all nursing staff on 2/3/2015. All nursing staff will be trained on the proper use and completion of form The Director of healthcare services or her designee will be responsible for ensuring that plans are kept current and up to date The Director of Healthcare Services will be responsible for tracking each and every update and review is completed and reviewed with the client and or their responsible representativeTo ensure that the highest possible level of quality assurance is being provided, these audits will continue in an regularly ongoing fashion indefinitely. . A copy of this has been uploaded for your review	

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	Assessments will be completed by a licensed nurse. For residents who have opted to self-administer medication(s), a specific assessment germane to the same will be utilized, as delineated in the policy regarding the resident's right to self-administer medication(s). Upon completion of an evaluation/assessment, the facility, using appropriately trained staff, shall identify and document the services provided to the resident by the facility, in the form of a service plan..."			